

CONSENT FORM FOR RESECTION OF COLON

PROPOSED TREATMENT

The doctor has explained that I, (name of patient) _____, have _____ and that an _____ is proposed.

About Colon & Rectum:

The large bowel (intestine) is made up of the colon and rectum (back passage). This part of the digestive tract carries the remains of digested food from the small bowel and gets rid of it as waste through the opening to the back passage (anus). Cells that line the colon and rectum may begin to grow out of control, forming a tumour (a growth of cancer cells).

The bowel has four sections: the ascending colon, the transverse colon, the descending colon and the sigmoid colon. Tumours can start in any of these areas or in the back passage. Tumours start in the innermost layer and can grow through some or all of the other layers.

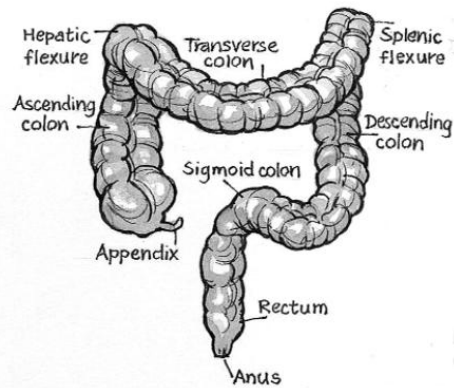


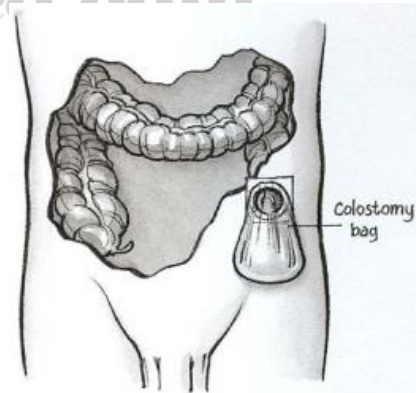
Diagram showing the parts of the bowel

The Procedure:

Surgery is the main treatment for tumours of the bowel. Usually, the tumour and a length of normal bowel on either side of the tumour (as well as nearby lymph nodes) are removed. The healthy parts of the bowel are then **stitched or stapled together (anastomosis)**.

If the bowel cannot be put back together or if the anastomosis is to be protected, an opening (stoma) will be made on the outside of the body for waste to pass out of the body. This is called a colostomy. A colostomy is made to allow waste to pass through an opening in the abdominal wall.

Sometimes, a temporary colostomy is needed until the joined bowel has healed, and then it can be put back.



A number of different surgical procedures are used depending on where the tumour is. These include:

- Right Hemicolectomy: Removal of the last part of the small bowel, the caecum, ascending colon and a small part of the transverse colon. Extended right hemicolectomy involves removal of entire transverse colon also.
- Left Hemicolectomy: Removal of the descending colon and sigmoid colon.
- Transverse Colectomy: Removal of the transverse colon.
- Sigmoid Colectomy: Removal of the sigmoid colon and nearby large bowel.
- Total abdominal colectomy: Removal of entire colon. The terminal part of small bowel is attached to the rectum.

General Preparations:

Before surgery, the bowel must be prepared. You will be on a clear fluid diet and given a medicated drink to help clean the large bowel. This can cause diarrhoea and cramps, and may be tiring. The medicated drink will completely empty your bowel. You will then fast for at least 6-8 hours before your surgery. If you are having a colostomy, the surgeon or a stoma nurse will discuss with you the best site for your colostomy and will mark the area with a marker pen. It is usually placed below your belt line, away from any other scars you may have and at least 8 - 10 cm away from your wound, depending on your size and shape.

Once inside operating room, **under a general anesthesia** a urinary catheter is placed in the bladder and you would be positioned for access to the chest, abdomen and pelvis. A thin flexible tube would be passed through your nose into stomach (nasogastric tube) to clear the contents in the stomach. This tube will be maintained for few days after surgery. To prevent complications such as infection, you will be given antibiotics at the time of your operation. To stop a blood clotting in your legs from happening a small injection of a drug known as anticoagulant will be given daily after the operation.

Modalities of Surgery:

- Laparoscopic:** One or more tubes are put into the abdomen and instruments passed down the tube to examine the inside of the abdomen and pelvis using a camera and video monitor. Sometimes, bands of fibrous tissue grow around the bowel or other organs. If so, the doctor may need to cut these. The surgeon looks for any signs that make the **procedure not viable (inoperability)** like spread of disease to liver or other sites. If operable, proceeds with one of the above mentioned procedures. The surgeon may **convert to open procedure** if the surgeon perceives that proceeding with laparoscopy may not be feasible.
- Open:** The surgeon opens the abdomen and examines the extent of the disease. The surgeon looks for any signs that make the **procedure not viable (inoperability)** like spread

of disease to liver or other sites. If operable, proceeds with one of the above mentioned procedures.

What are the risks of not having the procedure?

Symptoms including pain and bleeding may become worse and your bowel may completely block or burst. Without surgery, the disease may spread to other areas of your body.

Risks of the Procedure

The following are the commoner risks. There may be other unusual risks that have not been listed here. Please ask your doctor if you have any general or specific concerns.

I understand there are risks associated with any **anaesthetic** (see separate Anaesthetic Consent Form).

I may have side effects from any of the drugs used. The commoner side effects include light-headedness, nausea, skin rash and constipation.

I understand the procedure has the following **general risks and limitations**:

- Bleeding could occur and may require a return to the operating room. Bleeding is more common if you have been taking blood thinning drugs.
- I may develop a clot in a leg vein (deep vein thrombosis), causing pain and swelling. Part of this may break free and move to my lungs (pulmonary embolus), making me breathless. There is a small risk I could die.
- I may develop areas of minor collapse in the lungs, increasing my risk of getting a chest infection. I may require treatment with physiotherapy.
- Heart attack or stroke could occur from strain of surgery.
- Rarely death as a result of this procedure is possible.

I understand the procedure has the following **specific risks and limitations**:

- Leakage where the bowel was stitched together. This may need further surgery.
- My bowel may not function temporarily after the operation and I will not be able to eat or drink normally until its activity returns in a few days
- Structures near the operation site, including the ureters (tubes from the kidneys to the bladder), bladder and vagina may be damaged and require repair.
- Deep bleeding in the abdomen. This may need fluid replacement or blood transfusion or further surgery.
- Urinary tract infection. Antibiotics may be used to control the infection.
- Infection in the abdominal cavity. This may form an abscess may need drainage and antibiotics.
- The bowel may be unable to be joined and may be brought to the surface as a stoma, with the following problems:
 - The blood supply to the stoma may fail and cause damage. This may need further surgery.
 - Excess fluid loss from the stoma.
 - Stoma prolapse - the bowel protrudes past skin.

- Parastomal hernia - the bowel pushes through a weak point in the muscle wall, causing pain. Local skin irritation - reddening of the skin and a rash in reaction to the stoma bag glue.
- The wound may be abnormal and the wound can be thickened, red and painful.
- The bowel actions may be much looser after the operation than before.
- I may not be able to pass urine spontaneously for some days and in some cases may need a urinary catheter for several weeks.
- My wounds may become infected and this may delay healing and may require antibiotics or surgery.
- The colostomy may be too tight or too loose (causing a prolapse of the bowel or a hernia around the colostomy) and these may require revision. Colostomy closure requires a second surgery which would be planned few months after completion of your treatment.
- Loops of bowel may become stuck to the operation site (adhesions), causing blockages that may require further surgery. This can occur even years later.
- I may develop a weakness in the wounds (incisional hernia) that may require later treatment.
- My disease may recur.

I understand some of the above risks are more likely if I smoke, am overweight, diabetic, have high blood pressure or have had previous heart disease.

After the procedure:

After the operation the nursing staff will closely watch you until you have recovered from the anaesthetic. You may even be cared for in the intensive care unit immediately following your surgery. The recovery period after colon surgery varies. It usually involves a stay in the hospital from 3-10 days in uncomplicated cases. On return from your surgery you will have a catheter (plastic tube) in the bladder to measure and drain your urine. After surgery you will be given intravenous fluids (a drip) through which antibiotics may be given. The drip will remain in place until you are able to drink enough fluids.

Diet: During the first few days of recovery, you will not be able to eat until the bowel has begun to work again. You know the bowel has started to work again when you pass wind and/ or have a bowel movement. You will then begin to take liquids by mouth and then solid food.

Colostomy: If you have a colostomy, the colostomy drains bowel waste from the bowel into the colostomy bag. Most colostomy waste is softer and more liquid than normally passed bowel waste. The thickness of the bowel waste depends on where the stoma is.

You will be taught how to clean around the colostomy and change the colostomy bag.

The colostomy bag sticks to the skin around the stoma with special glue, and can be thrown away when dirty. This bag does not show under clothing, and most people learn to take care of these bags themselves. Wound Your wound will have stitches and/ or staples and is usually covered with a dressing, which may be adhesive plaster or a spray on plastic covering.

Drain: You may also have a small tube that drains into a bag or a bottle from near your wound. This is called a drain. The wound drain removes fluid from your wound and helps in the healing process. It is taken out when the drainage has dried up.

Your lungs and blood supply: It is likely that on your return from surgery you will be wearing elastic (anti-embolism) stockings. These are tight fitting stockings that are used to reduce the risk of blood clots forming in your legs. It is very important after surgery that you start moving as soon as possible. This helps to prevent blood clots forming in your legs and possibly going to your lungs. This can be fatal. Also, you need to do your deep breathing exercises. Take ten deep breaths every hour to prevent secretions in the lungs from collecting. If this happens, you may develop a chest infection. At all costs, avoid smoking after surgery as this increases your risk of chest infection. Coughing is painful after abdominal surgery.

Exercise: Expect to feel tired for some time after surgery. You need to take things easy and gradually return to normal duties, as you feel able to. It usually takes at least 6 months to get over the operation. You should not drive during the first 2-3 weeks. Do not lift heavy weights for at least six weeks after surgery. This is to prevent a rupture where the cuts were made and allow healing to take place inside.

Tell your doctor if you have:

- Large amounts of bloody leakage from the wound.
- Blood in the stool.
- Fever and chills.
- Pain that is not relieved by prescribed pain killers.
- Swollen abdomen.
- Swelling, tenderness, redness at or around the cut.

INDIVIDUAL RISKS:

DECLARATION BY PATIENT

I acknowledge I have read this form and the surgeon has informed me about the procedure, alternative treatments and answered my specific queries and concerns about this matter.

- I acknowledge that I have discussed with the surgeon any significant risks and complications specific to my individual circumstances that I have considered in deciding to have this operation.
- I understand that despite all expertise my disease might need the surgeon to **convert from laparoscopic to open procedure** any time during the operation.
- I agree to any other **additional procedures** considered necessary in the judgement of my surgeon during this operation.
- I understand that despite all studies my disease **may be inoperable** and the procedure might have to be stopped in between to protect me.
- I consent to a blood transfusion, if needed.
- I understand that a doctor other than the specialist surgeon may be part of the procedure.
- I have received a copy of this form to take home with me.
- Appropriate translation & explanations have been provided to me.

Signature of patient:

Date

Signature of witness or relative:

DECLARATION BY DOCTOR

- I declare that I have explained the nature and consequences of the operation to be performed, and discussed the risks that particularly concern the patient.
- I have given the patient an opportunity to ask questions and I have answered these.

Doctor's signature

Date

Dr Sandeep Nayak



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